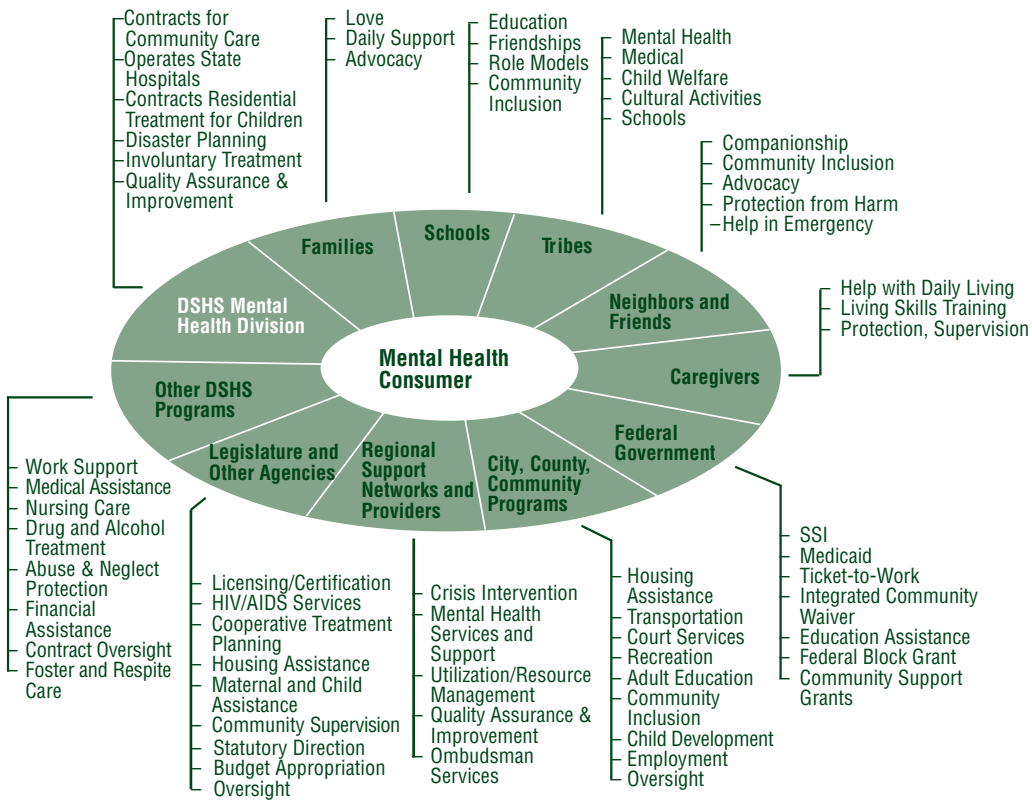
The DSHS Mental Health Division has many partners in helping people with mental illness achieve new optimism and opportunity.



New optimism and opportunity:

The Mental Health Division

Mental illness is an enduring part of the human condition that occurs in every culture. For most of human history, the mysterious nature of mental illness has made those who suffer from it subject to myth, superstition, and rejection. Severe mental illnesses have been mistaken for everything from demonic possession to divine inspiration. And as often as not in past centuries, the "treatments" for mental illness have been worse than the diseases.

Washington's first territorial institution was an "insane asylum," opened in 1871 on the site of Fort Steilacoom, where people with mental illness were locked away with little hope for recovery or release. For many, confinement to this institution was a life sentence. They endured physical restraints, isolation, immersion in ice water, frontal lobotomies, and electric shock therapy, to name just a few of the "innovations" in mental health treatment during the asylum's first hundred years.

Today, that institution has evolved into Western State Hospital and is one of three state-operated inpatient mental health facilities. Its continued existence is a testament both to our failure to find the causes and cures for mental illnesses, and to our continuing progress towards that elusive goal.

In the last 50 years, the pace of progress has quickened. In the early 1960s, the first wave of effective anti-psychotic medications came into widespread use, and prompted a slow-moving revolution in the treatment of mental illness. The new drugs stopped the hallucinations and voices that plagued people with schizophrenia and other psychotic disorders, and made it possible for many people to be released from mental hospitals and to lead productive lives. This first wave of anti-psychotic drugs, however came with a price: they brought on long-term side effects including uncontrollable twitching, low blood pressure, and blurred vision.

Today, new technologies make it possible to literally watch the human brain think. Current research offers renewed hope that we may eventually be able to sort out the genetic, biological and environmental origins of diseases like schizophrenia, depression, and bipolar disorder. And just in the last decade, a new generation of medications offers dramatic relief from the suffering and turmoil of some diseases, without some of the debilitating, long-term side effects of earlier drugs.

New research has made it clear that thinking, feeling and perception are largely biological functions of the brain, and that abnormalities in the way people think, feel and perceive the world around them are amenable to treatment.

Residents Receiving DSHS Services: SFY 2000

DSHS Services by Program	Total Clients
Mental Health Division	**112,105**
Community Support Services	107,515
Community Inpatient	10,805
State Hospitals	3,905

Source: The DSHS Client Data Base, Research and Data Analysis FY 2000

The result is that today, the vast majority of people with mental illness spend much less (if any) time in the hospital. While hospital care is still an essential part of the mental health system for both adults and children, more of our mental health resources are invested in outpatient care and pharmaceuticals. A combination of drugs and counseling is the dominant method of treatment, and for the most part, hospitalization is reserved for acute episodes of illness that are usually resolved when medications are adjusted or reintroduced.

There is a new optimism about both genuine recovery from mental illness, and about our ability to manage diseases in ways that make it possible for people to live as if they didn't have them. Schizophrenia, for instance, used to mean lifetime confinement to a mental hospital. Today, the right regimen of medication and treatment can eliminate most of the symptoms, most of the time.

Nonetheless, myths die hard, and the stigma of mental illness is, according to many people with mental illness and their families, as difficult to cope with as the illness. Parents of children with mental illness are still often blamed for their diseases. Adults still face prejudice, ignorance and misunderstanding. And the mental health system itself is still the stepchild of a health care insurance system that often limits or excludes treatment of even the most profound and painful mental illnesses.

In spite of our growing body of knowledge about mental illness - or maybe because of it - we are still unsure about how to define it. Prescription medications for depression are now marketed to millions on network television, and bookstores have entire sections devoted to semi-psychiatric self-help books. In some circles, long-term psychotherapy is considered a status symbol. There is an undeniable element of narcissism in our culture's enchantment with every conceivable form of therapy. At the same time, however, self-help books, informal support groups, pastoral counseling, and similar resources play a vital role in preventing life's ordinary miseries from becoming overwhelming or developing into serious mental illnesses.

Saving beautiful minds

Photo courtesy Della Jordan

Charan Bird suffers from schizophrenia. But she has "arisen" from mental illness into the world of normal consciousness, according to *The Seattle Post-Intelligencer*. "It is a life of an accomplishment fueled by sheer grit and a new generation of psychiatric drugs; of a strong spiritual life guided by her priest; and of a normal life threatened by a lack of money to pay for the medications she so desperately needs," according to the newspaper. And now, thanks to DSHS's Health Care for Workers with Disabilities Program, Bird receives the medication she needs for a total cost of $74 per month.

Read more about Bird's struggle with schizophrenia in *The Seattle Post-Intelligencer*'s story at Facing the Future Profiles, located at http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles

The confusion about where self-indulgence ends and genuine mental illness begins is addressed by a 1999 report on mental illness by the U. S. Surgeon General:

> There can be no doubt that an individual with schizophrenia is seriously ill, but for other mental disorders such as depression or attention-deficit/hyperactivity disorder, the signs and symptoms exist on a continuum and there is no bright line separating health from illness, distress from disease. . . The thresholds of mental illness or disorder have, indeed, been set by convention, but the fact is that this gray zone is no different from any other area of medicine. Ten years ago, a serum cholesterol of 200 was considered normal. Today, this same number alarms some physicians and may lead to treatment. Perhaps every adult in the United States has some atherosclerosis, but at what point does this move along a continuum from normal into the realm of illness? Ultimately, the dividing line has to do with severity of symptoms, duration, and functional impairment.
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> Mental Health: A Report of the Surgeon General, p. 39,1999

Thus, it's simply not clear where the dividing line between illness and ordinary misery is. But it is clear that over time, we are raising the standard of what constitutes mental health, and becoming more aggressive in our treatment of mental illnesses. Debilitating conditions such as depression, which used to be accepted as the inevitable result of a melancholy nature, can now be treated with considerable success. And conditions such as hyperactivity/attention deficit disorder - which have only recently been identified and defined - are the subject of both new treatments and new controversies.

Greater awareness of mental illness has led to more widespread acknowledgement that many of the people in our juvenile detention facilities, jails and prisons are mentally ill. This has probably always been true, and it has probably always been one of the reasons for the high rate of prison recidivism. Now there is at least some promise that public safety can be improved - and prison populations reduced - if offenders with mental illness get the treatment they need.

The public mental health system

Since the 1960s, Washington's public mental health system has changed dramatically. When the first wave of anti-psychotic medications made the release of thousands of hospital patients possible, there was a strong movement towards "de-institutionalization" of the mentally ill. One of three adult state mental hospitals was closed, and the size of the other two was reduced. In the early 1970s, this trend was helped along by new laws that made it harder to commit someone to a mental institution against his or her will.

But it took a long time for the promise of outpatient treatment and medication to take hold, and in the meantime, many people were set adrift in their communities. Some became homeless; others ended up in jail.

In the early 1990s, the state system was redesigned to address these problems. Primary responsibility for mental health was turned over to counties, and Regional Support Networks (RSNs) were established to administer care. Counties could choose to run their own RSNs, or join together and create multi-county RSNs. Today, there are 14 RSNs of widely varying geographic sizes and populations. Each RSN contracts with private providers of mental health care, and some RSNs also contract out administrative functions.

This wave of reform also included a move to managed care. Each RSN is allotted a specific amount of money to provide mental health services for people who live within its boundaries, and an allotment of beds for patients who need hospitalization at Western State Hospital, Eastern State Hospital, or the state-run Child Study and Treatment Center. Most - but not all - RSNs also use private psychiatric inpatient facilities that are closer to home.

Each RSN is responsible for managing a fixed budget, and for ensuring that everyone who is eligible for services in their area gets the mental health care they need. Generally speaking, public mental health services are intended for people who are eligible for Medicaid, except for emergency services, which are available to everyone.

Eligibility varies, however, from one RSN to another, because each RSN has its own assessment of new patients. Some assessments are designed to screen out all but the most seriously ill; others are somewhat more inclusive. There are core elements that are common to all RSN assessments, and these are used to collect statewide data, but variation in assessments is seen as a part of local control. So are variations in the breadth or intensity of services.

The definition of "emergency services" also varies from one RSN to another. Since people don't have to qualify for Medicaid to be eligible for emergency services, this means that some RSNs use more of their money than others to care for people who aren't poor enough to qualify for Medicaid. Statewide, about one third of the public spending on outpatient mental health care is for people who are not eligible for Medicaid. Most of these people either have no health insurance, or have insurance that doesn't cover the mental health services they need.

The availability of mental health services also varies because rural communities often lack mental health providers - especially for children - and this means that some people must travel long distances to receive care. In addition, the career path for many mental health and human service professionals generally begins with an assignment in a rural area or small town, and progresses towards larger, more urbanized areas. This means less experienced professionals often serve rural areas, and when they gain experience, they leave.

Challenges to the public mental health system

Health insurance and mental health

Although there has been pressure to include mental health on an equal basis with other kinds of care in health insurance policies, we are still a very long way from this goal. Most health insurance has very limited coverage for mental illness, in spite of the growing recognition that the diagnosis and treatment of mental

illness is as effective and reliable as other forms of medical care.

If health insurance included comprehensive benefits for the treatment of mental illness, and if everyone had health insurance, there would be no need for a separate public mental health system. Primary care physicians would be - as they are now in some managed care health insurance plans - the gatekeepers for mental health services, and these services would be regarded as an integral part of health care, just as cardiology or orthopedics are.

There would, however, be a continuing need for some of the supportive services that the public mental health system offers, such as help finding a place to live (and in some cases, providing special housing for the mentally ill), filling out paperwork, getting to appointments, and managing medications.

Integrated services

Not surprisingly, many people with mental illnesses have other problems, and need help with issues such as housing, income support or jobs. Mental illness involves whole families, and coping with children with mental illness may require a complex array of services. Many people with mental illnesses also "self-medicate" with alcohol or drugs, and need chemical dependency treatment. Elderly people or people with physical or developmental disabilities may also suffer from mental illnesses, and are at high risk for debilitating depression. People who are being released from both juvenile and adult correctional facilities need careful coordination of care so that they don't run out of psychotropic medications or become homeless.

All of these complex needs create the demand for a mental health system that can work in tandem with virtually every other provider of social services, as well as the criminal justice system. Providing this multi-faceted coordination of care with other agencies is a continuing challenge. When RSNs were created, there was hope that local agencies would be able to do a better job of this than the state-run system. Today, however, the need for better-coordinated services is still on the agenda.

Public safety

All across Washington, both local and state mental health systems are working to strengthen the connection between the mental health system and the criminal justice system for both juveniles and adults.

Estimates of the number of people in correctional facilities who are mentally ill vary widely, from 5 percent to 30 percent. Pierce County jail officials, who have extensive data on this issue, report that 16-23 percent of their inmates suffer from serious mental illnesses. This number, however, is from a study conducted in the early 1990s, and some correctional officials believe that the proportion of

Central Washington Comprehensive Mental Health

Services: Multi-service behavioral health agency, including a full range of outpatient mental health and chemical dependency services. Also operates a cluster of organizations, including Heritage Grove (in partnership with Yakima Valley Memorial Hospital) Gleed Orchard Manor and Dependency Health Services.

Communities served: Yakima, Kittitas, Klickitat, Chelan, Douglas, Grant and Benton counties

DSHS clients: 17,310

Private as well as public clients? Yes

Employees: 475

Payroll per year: $17.6 million

Total annual budget: $25.1 million

DSHS or federal funding brought into the community through contract with DSHS: $19.3 million

An artist's changing vision

Artist and photographer Mary McBride is a patient at Western State Hospital. According to *The News Tribune* of Tacoma, she suffers from bipolar disorder, which means cycles of mania and depression, and schizoaffective disorder, with mood changes that abate at times and are replaced by delusions and/or hallucinations. A judge first sent her to the hospital in 1992 for pulling a woman to the ground and stealing $20. As she recovers, her photography and drawings are attracting professional attention.

Read McBride's story in *The News Tribune's* profile on Facing the Future Profiles, located at http://www.wa.gov/dshs/FacingtheFuture/NewsProfiles

mentally ill people in jails and prisons is rising.

Whatever the number, there is an obvious public interest in making sure that people whose mental illness makes them a danger to themselves or others receive mental health treatment both while they are confined, and after they are released. There is also a public interest in keeping people with mental illnesses out of local jails, both because jail is expensive, and because many of the crimes committed by people with mental illness could be prevented if their illnesses were treated. Jail is also a frightening and brutal place for those who are not in touch with reality.

The need to do a better job of identifying and aggressively treating mentally ill offenders became a front-burner public issue in 1997 when a retired firefighter was fatally stabbed by a mentally ill man on a crowded street in Seattle. This man, who had a long history of both mental illness and violent crime, had been released from jail after being found incompetent to stand trial for a misdemeanor.

A new law was passed that encourages courts to commit those who are incompetent to stand trial to a state mental hospital. There, they are either to be restored to competency so that they can be tried, or confined until they are no longer a danger to themselves or others. Mentally ill offenders who are not a danger to themselves or others may be ordered to participate in outpatient mental health services and maintain a regimen of medication.

This new law has increased the number of offenders with mental illness who receive inpatient treatment, and new facilities are being created for this purpose. This, in turn, has created new demands on the mental health system and its budget.

The mental health system is also working more closely with the Department of Corrections and the Juvenile Rehabilitation Administration to ensure that adults and young people with mental illness get the treatment they need when they are released.

This increased emphasis on treating offenders with mental illness clearly makes sense. But it also makes advocates for the mentally ill uncomfortable, because they fear it can create stereotyping.

It's also hard to find providers who will take on these high-risk patients. Many mental health providers are reluctant to treat mentally ill offenders because they have a hard time finding liability insurance when they do.

Managing state mental hospitals

The mission and purpose of state mental hospitals has changed dramatically in the last 50 years, but they continue to be places of last resort - that is, the places where people end up when nothing else has worked, or when a mental illness or disorder is completely out of control. Caring for people in this condition is an immense challenge - and helping them find their way back to a decent life in their own community is even harder.

Eastern and Western State Hospitals serve people who are involuntarily committed because they pose a danger to themselves or

others, or are so gravely disabled that they are unable to care for themselves. They serve a growing number of offenders with mental illness. They serve people who have both developmental disabilities and mental illnesses. And they serve people with Alzheimer's disease and other forms of dementia if those persons are prone to violence and other behaviors that nursing homes can't manage. The Child Study and Treatment Center serves the most severely emotionally disturbed and mentally ill children. And the hospitals also serve as training grounds for mental health professionals, and as research sites for academics.

Each of these groups of people has distinct needs. Some, like patients with Alzheimer's, are slowly being moved out the state hospitals and into community-based facilities. But as the population of elderly people increases, the need for specialized facilities for dementia has outstripped the supply.

People with developmental disabilities also have distinct needs, not least of which is access to mental health professionals who can distinguish between their mental illnesses and the effects of their disabilities. This has led to lawsuits, and to the establishment of separate hospital wards for people with developmental disabilities. Advocates for people with developmental disabilities are also pushing for more specialized outpatient care so that fewer people with developmental disabilities are confined in mental hospitals.

State hospitals are not the only source for inpatient psychiatric care. But while private, inpatient psychiatric facilities exist in some hospitals and communities, there are large rural areas that have no inpatient facilities. The growing financial crisis of the hospital industry has caused the elimination of some hospital psychiatric wards, which exacerbates this problem and causes more pressure on the state hospital system.

Eligibility, federal requirements, and definitions of mental illness

Different levels of government have different conceptions of mental illness, and different ways or organizing services. The federal government includes Alzheimer's disease and other forms of dementia as mental illnesses; the state does not.

There are also differences between the state and federal government's priorities for who should get mental health treatment. The federal government considers anyone eligible for Medicaid a priority; the state places priority on people with acute, chronic or serious mental illness regardless of whether they're eligible for Medicaid.

There are also differences among RSNs in who gets treatment. This is possible because there is considerable elasticity in the state's definition of "acute, chronic or severe" mental illness. These are subjective terms, and while they eliminate people who may need only short-term counseling, they can also be used in ways that include or exclude a wide range of conditions. The same is true of the term "emergency services," which are provided without regard to income.

The result is that access to services varies from one RSN to another. Some families actually move to a different RSN in order to get better services for their mentally ill children or other family members.

This is a challenge to state policymakers who would like to think that they are making policy about access, eligibility, and services for the whole state.

Even in the most liberal interpretation of "acute, chronic or severe" mental illness, the mental health system excludes people who are in the early stage of illnesses that may become more severe, more debilitating, and more of a threat to public safety when they are left untreated. The concept of prevention - prevention of failure in school, job loss, homelessness, criminal behavior, and untold suffering - seems hardly to exist within the public mental health system. Even for children, mild or early stages of emotional disturbance do not merit prompt treatment.

In medical managed care systems, prevention and early intervention are important parts of the strategy for holding down costs. Patients are screened and tested for early signs of disease; doctors don't wait until a cancer has spread before they consider it serious enough to treat. But the public mental health system only treats people who have become acutely ill, because that is what they are funded to do.

Since the mental health system does not keep track of who is turned away and why they are turned away, it is impossible to measure the unmet need for mental health services or its impact on individuals, their families, and their communities.

Accountability for results

Like the rest of the medical establishment, mental health practitioners are struggling to adapt to an era in which they must be able to show that the treatments they provide really work, and that they are worth what we spend on them. This movement towards accountability for results and control of costs has only recently begun to take hold in the public mental health system, and it will be several years before it is fully developed.

While all RSNs must include certain core elements in their assessments of new patients, variations among RSNs will continue to make it difficult to collect uniform data across the state. Nonetheless, a uniform assessment and more closely defined treatment criteria would be strongly resisted by RSNs, who believe that they need flexibility to respond to local needs.

Organizational arrangements

Today's public mental health system consists of several layers:

- The federal Medicaid program
- The Mental Health Division of DSHS
- Regional Support Networks
- Contracted managed care agencies (in some, but not all RSNs), and
- Contracted providers of mental health services.

There is chronic tension between the layers of the system. Adversarial relationships between the state and RSNs, between RSNs and providers, and between providers and managed care agencies are common.

Most people who work in the system believe that the current managed care model is better than the previous fee-for-service system, in which costs spiraled out of control, resources weren't targeted to the most seriously ill, and there were no measures of accountability or efficacy. Nonetheless, most also believe that the current model is seriously flawed.

It's not clear whether these tensions in today's system are caused by its structure. Some people who have worked in the public mental health system for a long time report that this field has always been fractious; others believe that individual personalities or too much turnover in leadership at both the state and local level are to blame. There is no consensus on how the organization of mental health services might be improved, or how tensions within the system might be reduced.

It is also unclear whether the creation of RSNs has resulted in improved care for people with mental illness, reduced administrative costs, or achieved greater efficiency in the use of resources.

The most modern, state-of-the-art Center for Forensic Services in the nation began operation in March 2002 on the campus of DSHS's Western State Hospital in Lakewood. Based on lessons learned from similar facilities in other progressive states, the 167,000 square foot Forensic Center offers a therapeutic environment for mentally ill offender patients in a safe, secure setting that protects the public.

The Center for Forensic Services serves patients referred or committed by state Superior or District Courts in all 19 counties of Western Washington. Center staff provide inpatient competency evaluations, competency restoration and treatment for approximately 203 patients a day. The Center has a capacity of 238 patients.

Photo courtesy Western State Hospital